

		FOR OHF USE					

LL 1

**2001**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2001)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0041806</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Heartland Health Care Center-Galesburg</u>		<b>I have examined the contents of the accompanying report to the</b> <b>State of Illinois, for the period from</b> <u>01/01/01</u> <b>to</b> <u>12/31/01</u> <b>and certify to the best of my knowledge and belief that the said contents</b> <b>are true, accurate and complete statements in accordance with</b> <b>applicable instructions. Declaration of preparer (other than provider)</b> <b>is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>280 East Losey Street</u> <u>Galesburg</u> <u>61401</u> Number City Zip Code		<b>Intentional misrepresentation or falsification of any information</b> <b>in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Knox</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Barry Lazarus</u> (Title) <u>Vice President of Reimbursement</u>	
<b>Telephone Number:</b> <u>( 309 ) 343-2166</u> <b>Fax #</b> <u>( 309 ) 343-3289</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>	
<b>IDPA ID Number:</b> <u>344402510004</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>01/01/64</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input type="checkbox"/> <b>PROPRIETARY</b> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Craig Dekany, CPA</u> <b>Telephone Number:</b> <u>( 419 ) 252-5740</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Heartland Health Care Center-Galesburg# 0041806 Report Period Beginning: 01/01/01 Ending: 12/31/01

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>716</u>	<u>5,374</u>	<u>6,090</u>	8
9	SNF/PED					9
10	ICF	<u>6,139</u>	<u>8,709</u>	<u>1,598</u>	<u>16,446</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,139</u>	<u>9,425</u>	<u>6,972</u>	<u>22,536</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 89.48%

D. How many bed-hold days during this year were paid by Public Aid?

52 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 4/01/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 4/01/86 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 20 and days of care provided 5,137Medicare Intermediary Adminastar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/01 Ending: 12/31/01

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	104,905	8,438	5,707	119,050	827	119,877		119,877		1
2	Food Purchase		113,051		113,051	3,930	116,981	(2,609)	114,372		2
3	Housekeeping	55,639	8,250	664	64,553		64,553		64,553		3
4	Laundry	29,160	2,704	842	32,706		32,706	(7,993)	24,713		4
5	Heat and Other Utilities			86,044	86,044		86,044		86,044		5
6	Maintenance	25,510	5,931	30,220	61,661		61,661		61,661		6
7	Other (specify):*			712	712		712		712		7
8	<b>TOTAL General Services</b>	215,214	138,374	124,189	477,777	4,757	482,534	(10,602)	471,932		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	819,990	82,978	15,679	918,647	18,285	936,932		936,932		10
10a	Therapy	177,120	11,142	16,196	204,458		204,458		204,458		10a
11	Activities	32,888	2,824	2,155	37,867		37,867		37,867		11
12	Social Services	60,709	399	1,707	62,815		62,815		62,815		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,090,707	97,343	41,737	1,229,787	18,285	1,248,072		1,248,072		16
	<b>C. General Administration</b>										
17	Administrative	55,487		157,587	213,074	(50,209)	162,865		162,865		17
18	Directors Fees										18
19	Professional Services			3,641	3,641	(583)	3,058	(3,058)			19
20	Dues, Fees, Subscriptions & Promotions			34,335	34,335		34,335	(17,855)	16,480		20
21	Clerical & General Office Expenses	73,767	27,641	54,018	155,426	583	156,009	(24,793)	131,216		21
22	Employee Benefits & Payroll Taxes			324,330	324,330	6,082	330,412		330,412		22
23	Inservice Training & Education			1,471	1,471		1,471		1,471		23
24	Travel and Seminar			18,502	18,502		18,502		18,502		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			45,502	45,502		45,502		45,502		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	129,254	27,641	639,386	796,281	(44,127)	752,154	(45,706)	706,448		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,435,175	263,358	805,312	2,503,845	(21,085)	2,482,760	(56,308)	2,426,452		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number      Heartland Health Care Center-Galesburg      #0041806      Report Period Beginning:      01/01/01      Ending:      12/31/01

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			123,720	123,720	21,085	144,805		144,805			30
31	Amortization of Pre-Op. & Org.			389	389		389		389			31
32	Interest			45,076	45,076		45,076	(2,028)	43,048			32
33	Real Estate Taxes			45,579	45,579		45,579	5,003	50,582			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,120	27,120		27,120		27,120			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			241,884	241,884	21,085	262,969	2,975	265,944			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,961	13,825	225,786		225,786		225,786			39
40	Barber and Beauty Shops			6,895	6,895		6,895		6,895			40
41	Coffee and Gift Shops	9,669			9,669		9,669		9,669			41
42	Provider Participation Fee			37,777	37,777		37,777		37,777			42
43	Other (specify):*		23,125		23,125		23,125		23,125			43
44	<b>TOTAL Special Cost Centers</b>	9,669	235,086	58,497	303,252		303,252		303,252			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,444,844	498,444	1,105,693	3,048,981		3,048,981	(53,333)	2,995,648			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Heartland Health Care Center-Galesburg

# 0041806

Report Period Beginning: 01/01/01

Ending: 12/31/01

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,609)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,913)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(7,993)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,028)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,704)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,714)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,430)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,058)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,032)	21		24
25	Fund Raising, Advertising and Promotional	(17,855)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	5,003	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (53,333)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (53,333)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Heartland Health Care Center-Galesburg

ID# 0041806

Report Period Beginning: 01/01/01

Ending: 12/31/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Heartland Health Care Center-Galesburg

# 0041806

Report Period Beginning:

01/01/01

Ending:

12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,609)	0	0	0	0	0	0	0	0	0	0	(2,609)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(7,993)	0	0	0	0	0	0	0	0	0	0	(7,993)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(10,602)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(10,602)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,058)	0	0	0	0	0	0	0	0	0	0	(3,058)	19
20	Fees, Subscriptions & Promotions	(17,855)	0	0	0	0	0	0	0	0	0	0	(17,855)	20
21	Clerical & General Office Expenses	(24,793)	0	0	0	0	0	0	0	0	0	0	(24,793)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(45,706)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(45,706)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(56,308)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(56,308)</b>	<b>29</b>

## Summary B

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



Facility Name & ID Number Heartland Health Care Center-Galesburg# 0041806

Report Period Beginning:

01/01/01

Ending:

12/31/01

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc.	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	\$ 157,587	HCR Manor Care, Inc	100.00%	\$ 157,587	\$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	9,000		100.00%	9,000		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 166,587			\$ 166,587	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/01 Ending: 12/31/01

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Health Care Center-Galesburg # 0041806 Report Period Beginning: 01/01/01 Ending: 12/31/01

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HCR Manor Care, Inc  
 Street Address 333 North Summit St  
 City / State / Zip Code Toledo, OH 43604  
 Phone Number (419) 252-5500  
 Fax Number (877) 329-7731

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Dietary - Direct	Accumulated Cost	2,026,840,883	357 Nurs Fac	\$	\$	2,945,107	\$ 0	1
2	Dietary - Pooled	Accumulated Cost	2,425,139,746	357 Nurs Fac	680,609	406,990	2,945,107	827	2
3	Utilities - Direct	Accumulated Cost	2,026,840,883	357 Nurs Fac	154,435		2,945,107	224	3
4	Utilities - Pooled	Accumulated Cost	2,425,139,746	357 Nurs Fac	3,051,710		2,945,107	3,706	4
5	Nursing - Direct	Accumulated Cost	2,026,840,883	357 Nurs Fac	10,993,908	7,606,940	2,945,107	15,975	5
6	Nursing - Pooled	Accumulated Cost	2,425,139,746	357 Nurs Fac	1,902,166	1,264,589	2,945,107	2,310	6
7	General & Admin - Direct	Accumulated Cost	2,026,840,883	357 Nurs Fac	14,112,784	11,038,075	2,945,107	20,507	7
8	General & Admin - Pooled	Accumulated Cost	2,425,139,746	357 Nurs Fac	71,533,109	46,622,737	2,945,107	86,870	8
9	Employee Benefits - Direct	Accumulated Cost	2,026,840,883	357 Nurs Fac	2,156,484		2,945,107	3,133	9
10	Employee Benefits - Pooled	Accumulated Cost	2,425,139,746	357 Nurs Fac	2,428,174		2,945,107	2,949	10
11	Depreciation - Direct	Accumulated Cost	2,026,840,883	357 Nurs Fac	101,489		2,945,107	147	11
12	Depreciation - Pooled	Accumulated Cost		357 Nurs Fac	17,241,472		2,945,107	20,938	12
13									13
14	Interest				12,439,256				14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 136,795,596	\$ 66,939,331		\$ 157,587	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank of America		X	Finance Capital Additions	N/A		\$ 835,413	\$ 835,413			\$ 45,076	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 835,413	\$ 835,413			\$ 45,076	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 835,413	\$ 835,413			\$ 45,076	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Heartland Health Care Center-Galesburg**# **0041806**

Report Period Beginning:

**01/01/01**

Ending:

**12/31/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$	<b>40,576</b>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>45,579</b>	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>5,003</b>	3	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>45,579</b>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>50,582</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1996	<b>40,888</b>	8		
	1997	<b>42,724</b>	9		
	1998	<b>43,552</b>	10		
	1999	<b>42,064</b>	11		
	2000	<b>45,579</b>	12		
				<b>FOR OHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2000 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Heartland Health Care Center-Galesburg    COUNTY    Knox

FACILITY IDPH LICENSE NUMBER    0041806

CONTACT PERSON REGARDING THIS REPORT    Craig Dekany

TELEPHONE    ( 419 ) 252-5740    FAX #:    ( 419 ) 254-5495

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>9910427016</u>	<u>See Attached</u>	\$ <u>22,789.67</u>	\$ <u>22,789.67</u>
2. <u>9910427016</u>	<u>See Attached</u>	\$ <u>22,789.67</u>	\$ <u>22,789.67</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>45,579.34</u></u>	\$ <u><u>45,579.34</u></u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 18,716

B. General Construction Type:
 Exterior
 Masonry
 Frame
 Steel, fire resistant
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1983	\$ 54,305	1
2					2
3	TOTALS			\$ 54,305	3

Facility Name &amp; ID Number Heartland Health Care Center-Galesburg

# 0041806

Report Period Beginning:

01/01/01

Ending:

12/31/01

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		1964	1964	\$ 407,801	\$	30	\$	\$	\$ 407,801	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>CURRENT YEAR DEPRECIATION</b>										
10	Building Improvements		1968		73	79,013		79,013		584,660	9
11	Building Improvements		1969		1,059						10
12	Building Improvements		1970		1,083						11
13	Building Improvements		1971		10,602						12
14	Building Improvements		1972		5,946						13
15	Building Improvements		1973		758						14
16	Building Improvements		1974		817						15
17	Building Improvements		1975		3,645						16
18	Building Improvements		1978		19,333						17
19	Land Improvements		1983		1,350						18
20	Building Improvements		1984		21,913						19
21	Building Improvements		1985		42,479						20
22	Land Improvements		1985		8,457						21
23	Building Improvements		1986		23,347						22
24	Land Improvements		1986		2,349						23
25	Building Improvements		1987		19,172						24
26	Building Improvements		1988		14,265						25
27	Land Improvements		1988		1,470						26
28	Building Improvements		1989		36,615						27
29	Land Improvements		1990		1,500						28
30	Building Improvements		1990		27,793						29
31	Building Improvements		1991		9,501						30
32	Building Improvements		1992		24,536						31
33	Building Improvements		1993		16,600						32
34	Land Improvements		1994		3,095						33
35	Building Improvements		1994		1,278						34
36											35
											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Heartland Health Care Center-Galesburg

# 0041806

Report Period Beginning:

01/01/01

Ending:

12/31/01

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Land Improvements	1995	\$ 1,098	\$		\$	\$	\$		37
38	Building Improvements	1995	14,214							38
39	Building Improvements: Renovation of 4 bed area: Architect and	1996	23,693							39
40	engineering fees, demolition, masonry, concrete, drywall,									40
41	windows, doors, wood trim, paint, counter tops, electrical									41
42	Building Improvements : Wallcovering	1996	79,684							42
43	Building Improvements : Carpet and vinyl	1996	33,131							43
44	Building Improvements : Ceramic flooring	1996	40,886							44
45	Building Improvements : Millwork	1996	25,990							45
46	Building Improvements : Electrical lighting, plumbing fixtures, hand	1996	51,580							46
47	rails, mirrors, lighting fixtures, signs, upgrade of alarm system,									47
48	vinyl flooring									48
49	Building Improvements : Doors	1997	10,728							49
50	Building Improvements : Electrical composite, automatic doors,	1997	38,947							50
51	metal doors, fire alarm system									51
52	Building Improvements : Capalo	1997	2,500							52
53	Building Improvements : Generator	1997	7,743							53
54	Building Improvements : Heating, Ventilation, Air Conditioning	1997	466,556							54
55	Building Improvements : Onan Genator	1997	17,482							55
56	Building Improvements : Soffits, gutters & trim	1997	9,962							56
57	Building Improvements : Generator	1997	24,885							57
58	Land Improvements - Sidewald	1998	7,988							58
59	Building Improvements - Fire Prevention System	1998	35,013							59
60	Building Improvements - HVAC	1997	42,499							60
61	Sidewalk	1999	7,988							61
62	Sidewalk	1999	900							62
63	Overhead from const	1999	2,681							63
64	Power control wiring for ne	1999	2,392							64
65	Sprinkler system upgrade	1999	19,107							65
66	Air compressor	1999	598							66
67	Laundry room floor	1999	1,800							67
68	Sprinkler upgrade	1999	23,940							68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,700,822	\$ 79,013		\$ 79,013	\$	\$ 992,461		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,700,822	\$ 79,013		\$ 79,013		\$ 992,461	1
2	Fire sprinkler system	1999	2,971						2
3	Boiler	1999	33,600						3
4	HVAC upgrade	1999	2,420						4
5	Building improvements	1999	1,200						5
6	SMOKING HUT	2000	4,950						6
7	CONCRETE FOR SMOKE HUT	2000	350						7
8	CABINETRY	2000	3,690						8
9	ELECTRICAL	2000	20,205						9
10	ADD'T'L COST SMOKING HUT	2000	645						10
11	ELECTRICAL	2000	10,880						11
12	ELECTRICAL	2000	3,454						12
13	HVAC	2000	21,662						13
14	ELECTRICAL/NEW OFFICE	2000	860						14
15	CABINETS	2000	1,369						15
16	HVAC	2000	1,736						16
17	HVAC	2000	193						17
18	ADD'T'L COST FOR SPRINKLER SYST	2000	15,146						18
19	AIR / HUMIDIFIER COIL	2001	5,233						19
20	CANOPY	2001	1,200						20
21	CONCRETE PATIO	2001	5,500						21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,838,084	\$ 79,013		\$ 79,013		\$ 992,461	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 761,286	\$ 44,707	\$ 44,707	\$		\$ 565,824	71
72	Current Year Purchases	71,625						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION		21,085	21,085				74
75	TOTALS	\$ 832,911	\$ 65,792	\$ 65,792	\$		\$ 565,824	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,725,300	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 144,805	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,805	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,558,285	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 18,463

Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Resident Transportation</u>	<u>1997 Ford Van</u>	\$ <u>721.42</u>	\$ <u>8,657</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>721.42</u>	\$ <u>8,657</u>	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2002 \$                     

13.                      /2003 \$                     

14.                      /2004 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a	3694	hrs	\$ 81,041	145	\$ 3,613	\$ 895	3,839	\$ 85,549	1
2	Licensed Speech and Language Development Therapist	10a	1701	hrs	37,300	298	7,460	7	1,999	44,767	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	2680	hrs	58,779	205	5,123	332	2,885	64,234	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts			4,888	211,961		216,849	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): X-Ray, Lab, IV Therapy						8,937	9,908		18,845	13
14	TOTAL				\$ 177,120	648	\$ 30,021	\$ 223,103	8,723	\$ 430,244	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 63,237	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (22,663) )	624,144		3
4	Supply Inventory (priced at )	15,727		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	640		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 703,748	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	96,000		13
14	Buildings, at Historical Cost	1,796,390		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	834,523		16
17	Accumulated Depreciation (book methods)	(1,558,285)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,168,628	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,872,376	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 53,974	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,382		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,579		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Other Accrued Expenses</u>	(5,534)		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 207,401	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	835,413		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 835,413	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,042,814	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 829,562	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,872,376	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>693,481</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>693,481</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>476,432</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>476,432</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Changes in interdivision</b>	<b>(340,351)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(340,351)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>829,562</b>	<b>24 *</b>

\* This must agree with page 17, line 47.



**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,834,525	1
2	Discounts and Allowances for all Levels	(71,667)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,762,858	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	464,558	6
7	Oxygen	5,685	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 470,243	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,812	12
13	Barber and Beauty Care	8,353	13
14	Non-Patient Meals	1,616	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	36	16
17	Sale of Drugs	227,945	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	34,540	19
20	Radiology and X-Ray	938	20
21	Other Medical Services	9,079	21
22	Laundry	7,993	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 292,312	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,525,413	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	477,777	31
32	Health Care	1,229,787	32
33	General Administration	796,281	33
	<b>B. Capital Expense</b>		
34	Ownership	241,884	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	303,252	35
36	Provider Participation Fee		36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,048,981	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	476,432	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 476,432	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number Heartland Health Care Center-Galesburg

# 0041806

Report Period Beginning: 01/01/01

Ending:

12/31/01

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,141	1,252	\$ 26,505	\$ 21.17	1
2	Assistant Director of Nursing	3,762	4,128	73,661	17.84	2
3	Registered Nurses	4,185	4,592	78,451	17.08	3
4	Licensed Practical Nurses	14,282	15,672	203,664	13.00	4
5	Nurse Aides & Orderlies	46,304	50,808	423,682	8.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,675	8,071	177,120	21.95	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,230	3,543	32,888	9.28	10
11	Social Service Workers	4,255	4,669	60,709	13.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,428	13,636	104,905	7.69	15
16	Dishwashers					16
17	Maintenance Workers	1,917	2,105	25,510	12.12	17
18	Housekeepers	7,210	7,911	55,639	7.03	18
19	Laundry	3,612	3,964	29,160	7.36	19
20	Administrator	1,779	2,080	55,487	26.68	20
21	Assistant Administrator					21
22	Other Administrative	1,921	1,921	27,831	14.49	22
23	Office Manager					23
24	Clerical	5,493	5,586	55,605	9.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,652	1,814	14,027	7.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,846	131,752	\$ 1,444,844 *	\$ 10.97	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	6,000	Line9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,000		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## **XIX. SUPPORT SCHEDULES**

[illegible]

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

[illegible]

Facility Name & ID Number **Heartland Health Care Center-Galesburg**

STATE OF ILLINOIS

# **0041806**

Report Period Beginning:

**01/01/01**

Ending:

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**12/31/01**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA \$3208
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5-10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,472 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
Galesburg Nursing & Rehab Center #29504. Transferred to HCR 8/15/96
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 37,777  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,616
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? \_\_\_\_\_  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100 %  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.